

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032297

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District 1002

Registrar's No. 4656

STATE FILE NUMBER

FILED SEP 13 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>50 yrs.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>2607 West 75th Terr.</b>	
416 East 36th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>GER TRUDE LAURA JOHNSON</b>			4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-1884</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (retired)</b>			11. BIRTHPLACE (City and state or country) <b>New Sharon, Iowa</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>Duff &amp; Repp Furn. Co.</b>			12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Flander Benidict</b>		13b. MOTHER'S MAIDEN NAME <b>Roberts</b>		14. NAME OF HUSBAND OR WIFE <b>William Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		
17. INFORMANT <b>James Phillip Johnson-2607 W. 75th Terr</b>			Address		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>Chronic</b>
DUE TO (b) <b>cerebral arterio-sclerosis</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension - Cardiovascular disease</b>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
---	--	---	--	--	--

20c. TIME OF INJURY Hour <b>3:00</b> a.m. <b>PM</b> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	

21. I attended the deceased from <b>9-30-54</b> to <b>8-21-63</b> and last saw her alive on <b>8-15-63</b>	
Death occurred at <b>3:00 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>Daniel J. Elias M.D.</b>		22b. ADDRESS <b>9306 E. 40th - Indep. mo</b>		22c. DATE SIGNED <b>8-22-63</b>	
---	--	---	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>8-23-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Crematory</b>	
23d. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b>		ADDRESS <b>Linwood &amp; Woodland</b>		23e. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	

25. DATE RECD. BY LOCAL REG. <b>8-22-63</b>		26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>	
--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Daniel J. Elias

VS 300 Rev. 4/59	DATE AMENDED
1	
2 3898	
3	
4 1	
5 2	
6	
7 1	
8 2	
9 331X	
10	
11	
12 86-0	
13	

Dr. David J. Elias  
9306 A. E. 40 Highway  
(Blue Ridge Clinics)  
716-2000  
2-5:30 Thurs.

2 cc

18

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James E. Hackleman*

Licensed Embalmer No. 4523

P. O. Address HC Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.